

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-62-046593

STATE FILE NUMBER

DO NOT WRITE
ON THIS STUB

AMENDED

Register's District No. 128

Primary Registration District No. 2000

Registrar's No. 1824

1. PLACE OF DEATH

a. COUNTY

GREENE

b. CITY (If outside corporate limits, give TOWNSHIP only)
OR TOWN

SPRINGFIELD

Length of stay in lb

8 DAYS

c. FULL NAME OF (If NOT in hospital, give location)
HOSPITAL OR INSTITUTION

BURGE HOSPITAL

Inside Limits

Yes ☒ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)

a. STATE

MO

b. COUNTY

LACADE

admission)

c. CITY

OR

TOWN

CONWAY

Inside Limits

Yes ☒ No ☐

d. STREET

ADDRESS

(If outside, give location)

Reside on Farm

Yes ☐ No ☒

3. NAME OF DECEASED

(Type or print)

CARA

First

PAYNE

Last

Month

Day

Year

DATE OF DEATH

DEC 8

1962

5. SEX

MALE

6. COLOR OR RACE

WHITE

7. Married

☒ Never Married ☐ Widowed ☐ Divorced ☐

8. DATE OF BIRTH

8-24-1908

9. AGE (last birthday)

54

IF UNDER 1 YEAR

Months Days Hours Min.

IF UNDER 24 HR

Months Days Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

FARMER

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (City and state or country)

MISSOURI

12. CITIZEN OF WHAT COUNTRY

U.S.A.

13a. FATHER'S NAME

MANSUR PAYNE

13b. MOTHER'S MAIDEN NAME

MARY SHUM

14. NAME OF HUSBAND OR WIFE

AULA

15. WAS DECEASED EVER IN U.S. ARMED FORCES?

(Yes, no, or unknown) (If yes, give war or dates of service)

YES WWII

17. INFORMANT

AULA PAYNE

Address

CONWAY MO

18. CAUSE OF DEATH (Enter only one cause per line for PART I. DEATH WAS CAUSED BY:

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

Respiratory insufficiency

INTERVAL BETWEEN ONSET AND DEATH

1 week

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.

DUE TO (b)

Cancer of Throat

2 years

DUE TO (c)

Cancer of Larynx

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)

PART III. If deceased was female was there a pregnancy in last 90 days.

☐ Yes ☐ No ☐ Unknown

19. WAS AUTOPSY PERFORMED?

YES ☐ NO ☒

20a. ACCIDENT

☐

SUICIDE

☐

HOMICIDE

☐

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)

20c. TIME OF INJURY

Hour a.m. p.m.

Month, Day, Year

20d. INJURY OCCURRED WHILE AT WORK

☐ NOT WHILE AT WORK ☐

20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

20f. CITY, TOWN, OR LOCATION

COUNTY

STATE

21. I attended the deceased from 1961 to 12-8-62 and last saw her alive on 12-8-62

Death occurred at 8:00 p.m. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE

Robert B. Stewart, M.D.

(Degree or title)

22b. ADDRESS

600 S. Glenstone Sp'd. Mo

22c. DATE SIGNED

12-15-62

23a. BURIAL, CREMATION, REMOVAL (Specify)

REMOVED 12-8-1962

23b. DATE

23c. NAME OF CEMETERY OR CREMATORY

BAPTIST

23d. LOCATION (City, town, or county)

CONWAY MO

(State)

24. FUNERAL DIRECTOR

BARBER-EDWARDS

ADDRESS

MARSHFIELD

25. DATE RECD. BY LOCAL REG.

12-18-62

26. REGISTRAR'S SIGNATURE

Effie E. Meehan

FEB 25 1963

DEC 27 1962

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed

George Stapp

Licensed Embalmer No. _____

P. O. Address

1961
W. J. Davis, 1960

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).
If embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.

permitted Dec 27, 1962